# Bulletin

OF THE NATIONAL TUBERCULOSIS ASSOCIATION

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**TB Must Be Fought on All Fronts**

**NTA To Explore Expansion Into Other Respiratory Diseases**

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**ATS Committee Evaluates Place of Drugs in TB Therapy**

**More Local Health Units Needed**

"The public tuberculosis hospital should, whenever possible, become, in a measure, the hub of the wheel for community tuberculosis control."

MAR 13 1950

# Across the EDITOR'S DESK

## Patient Morale—A Budget Item

One principal conclusion which may be drawn from falling tuberculosis death rates is that they can be brought still lower. While the pattern of cause and effect is not always crystal clear, it seems apparent that aggressive case finding and adequate treatment are two factors which can contribute substantially toward eventual eradication of this disease. Of these two preventive measures, case finding has recently received more general attention, possibly because of its tangible and spectacular apparatus.

Some of our tuberculosis hospitals have kept pace with current advances in case finding and some have not. Some are readily accepted by newly discovered patients; some still encounter resistance to hospitalization from patients and their families. Sometimes the causes are to be found in false economies in hospital budgets. It should be apparent that no administrator can provide substantial therapeutic and preventive contributions to tuberculosis control with a budget at the level of the poor farm, the jail, or the asylum.

However, more factors than money are involved. One of them is the morale of the patient group. Good hospital morale may be measured by the number of patients who complete their treatment, thus protecting the community as well as themselves. A hospital contributes to tuberculosis control in direct ratio to the proportion of patients who are discharged with medical consent. Studies of patient behavior indicate that good morale weathers disappointments, tedium, and the long period which is essential to secure recovery. Poor morale may waste taxpayers' money.

Some poor morale is the result of serious economic factors which require major and far-reaching changes in public welfare services. Frequently, however, an apparently trifling detail sets off emotional explosions, some of which lead to abrupt termination of treatment. The trigger item may be anything at all—cold cereal, a delay in mail delivery, a slamming door. Some physicians and nurses understand this phase of human behavior very well and take it, professionally, as a part of sickness. Others regard it as sheer tantrum. To the patient, however, the apparent trifle is the straw that broke the camel's back.

A number of tuberculosis associations whose modest budgets do not justify the employment of technical staffs have given attention to patient morale in their programs. They are demonstrating in simple ways, such as providing reading matter, how stabilized morale can improve patient cooperation. Such projects often require more thought than money.

Such a demonstration may begin by studying what takes place in the battle with monotony and boredom, which push many patients toward hysterical explosion. For example, is the reading matter available on the wards current, suitable, and adequate? Is the library collection limited to discards from someone's attic? Is a book-cart available to get books to bed-fast patients? How much encouragement do patients receive through the mails? What are the facilities for radio reception? What kind of records are available for the public address system? Is an occupational therapy service hampered by lack of simple materials? Is there a canteen or some other source of small comforts, real and fancied?

When normal occupations are precluded by

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**B U L L E T I N**

**OF THE**

**NATIONAL TUBERCULOSIS ASSOCIATION**

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The editors welcome articles for possible publication. If an article deals with a subject on which there may be differences of opinion, the BULLETIN will be glad to consider presentation of varying opinions in the same or subsequent issues.

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# Integrating TB Services

## All-Out Attack on Disease Calls For Well Coordinated and Integrated Program with Proper Emphasis on Socio-Economic Factors and Continuity of Service

By ROBERT E. PLUNKETT, M.D.

THE editorial in the December, 1949, issue of the BULLETIN again brings into bold relief the fact that tuberculosis is a socio-economic problem of major proportion. Provision of public funds for an all-out attack on this disease is justified because of its constant threat to the public health. However, it is one thing for the "expert" in public health and tuberculosis control glibly to talk about the enormous cost of this disease and quite another thing for the same authorities to coordinate their thinking and action and do something effective about it.

We know the cause of tuberculosis; we know how it is spread; we know how to prevent and treat it. Up to the present, however, we have not put our knowledge to work to its fullest possible extent.

When the many problems presented by tuberculosis control are discussed, health or tuberculosis workers often assert with bland assurance that they are doing everything that is necessary. They point to their sanatoriums, clinics, mass X-ray projects, rehabilitation services, and health education programs. Yet they have but the vaguest answers to such a question as, "How are these services integrated and is proper emphasis put upon socio-economic factors?"

### Major Challenge

This question poses one of the major challenges in meeting the impact of tuberculosis. Too much emphasis cannot be placed upon the fact that the presence of tuberculosis in an individual is a symptom of a socio-economic and public health problem in the community.

It takes but a cursory review of available information in the records of health departments, hospitals, welfare departments, insurance companies, and social agencies to conclude that, whether he knows it or not, the taxpayer is footing the bill for this preventable and costly disease. When he becomes aware of this, he will want to know whether he is receiving the maximum possible returns from his tax dollar. In the absence of a well coordinated or integrated program *on all fronts* in the attack on this disease, we must in all honesty tell him that he is not.

### Short-Sighted Economy

As an example, the taxpayer may be told that families who can afford it, as determined by the application of the "means test" or some modification of it, are required to pay for diagnostic or treatment services. This is a misleading reassurance and is, in addition, short-sighted economy, because the general application of the "means test" drives many families so far down the economic scale as ultimately to increase the number of tax consumers at the sacrifice of maintaining or increasing the number of tax producers. Moreover, it should again be emphasized that, as the economic line goes down, the prevalence of tuberculosis goes up. Low economic status means overcrowding, malnutrition, and medical neglect. All these play a part in lowering resistance to disease and serve to create a favorable soil for the growth and spread of the tubercle bacillus.

Although tuberculosis is a family and community disease, its occurrence in an individual should be of prime concern to the physician and all possible public facilities should be provided to bring the disease process under control. Nevertheless, the physician's responsibility extends beyond the individual patient. Several years ago the National Tuberculosis Association had a slogan, "From whom did he get it; to whom did he give it?" Physicians who fail to keep this uppermost in their thinking and who fail to promote or initiate steps to secure the answer fail to fulfill their obligation in attacking this communicable disease.

### TB Hospital the Hub

The public tuberculosis hospital should, whenever possible, become, in a measure, the hub of the wheel for community tuberculosis control. The medical staff has much to contribute outside the four walls of the hospital by being available for consultation as a public service, by acting as clinicians in local diagnostic and follow-up clinics, by joining with health officials in directing public health nursing service, and planning epidemiological services or research. Moreover, in following up cases and contacts, the opinion of the tuberculosis clinician is important if public funds are to be conserved. The reliability of epidemiological administration will be found to be in direct ratio to the accuracy of clinical and bacterio-


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logical classification of the disease.

Because of the chronic and relapsing nature of the disease, the idea of "continued care" instead of "after care" deserves more prominence in our thinking and planning toward control. Experience indicates that the hospital tuberculosis specialist is looked upon as a symbol of service and, in periodically appraising the clinical status of patients, his presence in local clinics provides a continuity of service which is invaluable in a truly effective control program.

**Family Physician Needed**

Essential also to the successful continuation of such a public service is the cooperation, if not the direct participation, of the "family physician." Any program involving such a human problem as tuberculosis which ignores the private physician is bound to be unproductive of positive community results. From the public health and the clinical point of view, the active support of the private physician to a public tuberculosis service is reciprocally beneficial. This is so in many respects, one of the most important of which is the provision of free consultation in diagnosis and treatment, which will conserve family assets and thereby make it possible to meet the cost of other illnesses.

That this is not wishful thinking is evidenced by the fact that in areas where a coordinated scientific approach is made to the tuberculosis problem, the triad of the tuberculosis hospital, the family physician, and the health department presents a united front, the attacking advance of which cannot be halted.

In addition to the clinical and epidemiological contributions which the tuberculosis physician may make toward the tuberculosis control problem, there are the sociological factors. Fortunately, most tuberculosis clinicians follow the precept laid down by the late Doctor Osler when he said that in dealing with tuberculosis, "It is many times more important to know what kind of person has tuberculosis than to know what kind of tuberculosis a person has." The science of medicine cannot explain all of the manifestations of illnesses. This is particularly so in a chronic and relapsing disease like tuberculosis. Therefore, the science of man must be brought into play if the needs of the patient as a person are to be met.

Inasmuch as many of the causes of emotional conflict exist in the home, the factory, or in the community, it would be futile to expect the hospital physicians, nurses, or other personnel effectively to solve many of these problems. To be sure, the hospital personnel may be able to prepare a blueprint of the clinical and mental needs of a person afflicted with this disease, but the development of adequate service and assistance to meet such needs requires the coordination, indeed the integration, of many private and public local agencies. In these agencies will be found professional personnel competent to expedite financial, employment, insurance, and other problems which adversely affect the welfare of the patient or the family.

**Must Find Solution**

If we are to avoid the development of additional cases of tuberculosis, a solution must be found to meet the sociological and health needs of the family, particularly when the wage earner is in a tuberculosis hospital. The tuberculosis specialist, who is familiar not only with the clinical status of the patient but also with the household contacts, can be very influential with welfare departments in securing appropriate assistance primarily as a health measure.

The conclusion, therefore, is that tuberculosis is a disease which is costing the taxpayers hundreds of millions of dollars. It is a socio-economic problem because it is the most costly infectious disease.

The expenditure of public funds is justified not on the basis of medical care exclusively but as a public health service to prevent the spread of the disease.

It is a medical problem of a highly specialized nature because of its chronic and relapsing characteristics.

Persons who have the disease and who accept treatment and isolation not only are doing their part in the fight to regain their health but are making a lasting contribution to community health by assuring family members and others that they are not spreading the disease.

All public agencies and workers in the field of public health and welfare should take stock immediately and periodically of the extent and distribution of tuberculosis and evaluate the effectiveness of the total program of control.

**Definite Responsibilities**

Voluntary agencies, particularly the NTA and its affiliates, have very definite responsibilities to inform the public and legislative bodies of the need for adequate appropriations whereby these public agencies can most effectively attack this problem.

Moreover, it is their responsibility to cooperate in bringing about an effective coordination of all community forces in a dynamic drive against tuberculosis. An added responsibility is constantly and effectively to inform the public of the need for accepting the preventive and treatment services provided by these public agencies.

Here are the questions we must ask and promptly answer:

1. How completely are the various programs coordinated or integrated?

2. Are first things done first?

3. Is effort wasted on the easiest and perhaps the least productive phases of the control program?

4. Is "team work" just a euphonious term or is it actually working?

5. How effective is the health education?

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# Working With the Sanatorium

## Mutual Respect, Clear Definition of Responsibilities, and Courtesy Listed as Prime Factors in Establishing and Maintaining Good Working Relations

By GERTRUDE ECKHARDT, R.N.

IF all tuberculosis associations and sanatoriums operated in complete harmony, there would be little need for this article. The fact is that there is opportunity for improvement in the working relations within our own family of tuberculosis workers. If this were not so, we would be unique, for working cooperatively is a problem that plagues all groups. If we were inspired by the wisdom of a Solomon, and could spell out a few rules guaranteed to solve this universal problem, we would be the envy of national and international governing bodies.

Our aims are less pretentious. Our first is to point out three basic factors essential to developing and maintaining good working relations between a sanatorium and a tuberculosis association.

### Mutual Respect Essential

The first is mutual respect, born of ability, sincerity of purpose, and performance. The sanatorium superintendent must believe that the staff of the tuberculosis association is prepared for its job, that the individual workers are genuinely interested in tuberculosis control, that the work and the business of the association are carried out efficiently.

Likewise, the staff and the directors of the tuberculosis association must respect the sanatorium personnel. They must know that the patients receive the best medical and surgical treatment under conditions as pleasant as possible, in an atmosphere of kindness.

By pointing to mutual respect as the most important factor in developing and maintaining good relations, one is placed in the unhappy position of suggesting what is to be done if respect does not exist in the desired measure.

First we must give honest answers to the following questions:

Are the criticisms real or a matter of hearsay?

How much of the misunderstanding is a matter of inherited prejudice?

How much is due to personality clashes?

How recently has any effort (actual crow-eating effort) been made to straighten out situations?

What actual assistance has been given in helping, for instance, to revitalize the association's program, to help the sanatorium superintendent secure the personnel, equipment, or facilities necessary to make his institution first rate?

Souls must be searched to determine whether the proportions of the possible difficulty are gigantic enough to justify the blight which poor cooperation places on the tuberculosis control program.

The wisdom of the policy of many organizations to keep the administration of the association separate from the administration of the county sanatorium becomes apparent.

### Clear-Cut Responsibility

The second factor essential to maintaining good relations is the clear definition of responsibilities. Each group has its own talents, training, experience, importance, and opportunity for service. How much grief would be avoided if this fact were kept in mind!

The sanatorium superintendent, through his years of training and experience, has earned the position of being the authority on medical aspects of tuberculosis control—a position which he justly guards. His recommendations on the medical aspects of any tuberculosis program should be sought—and early—in planning any control program, such as X-ray surveys, nursing services, clinics, rehabilitation programs, and health education.

Given the blessing and guidance of the medical authority, the approval of the medical society, the cooperation of health departments, and allied community agencies, the tuberculosis association has a clear field. Here is its share of responsibility. Here its talents and experience in fact finding, joint community planning, education, organization, promotion and public relations, have full sway. Clearly, it is a division of responsibility, rich in opportunity for the exercise of our talents of initiative and service for others.

### Courtesy Is Important

We are listing courtesy as the third essential factor on which good relations are built. We take the liberty of endowing the word "courtesy" with some of the qualities of the Schmoo. It turns up in the form of giving credit in generous measure for jointly-sponsored projects. Glory gained through taking undeserved credit is hollow and short-lived.

It can be found in the word "loyalty." Criticism of an institution or the tuberculosis agency should not be tolerated unless, of course, it is justified and the proper authority has made neither proper


### THE AUTHOR

Miss Eckhardt is the executive director of the Bergen County (N.J.) Tuberculosis and Health Association, a position she has held since 1933, with the exception of a period of three years, when she served in the Army Nurse Corps. A native of New Jersey, Miss Eckhardt is a graduate of the School of Nursing, Presbyterian Hospital, New York City, and holds a Master's degree in Adult Education from Columbia University. Her article is a contribution from the Advisory Committee on Public Relations of the National Conference of Tuberculosis Secretaries.

explanation nor any effort to correct the situation.

It can be found in so simple a gesture as asking an opinion, giving a suggestion, offering assistance beyond the call of duty, offering assistance in an emergency, and in tolerance and understanding.

It should not be assumed from the foregoing discussion that poor cooperation is the rule. There are hundreds of communities throughout the United States which are proud of their tuberculosis programs carried on cooperatively between sanatoriums and tuberculosis associations and local health departments.

As an illustration, let me describe three tuberculosis control services carried on by the Bergen County (N. J.) Tuberculosis and Health Association in cooperation with Bergen Pines Hospital. The services have the approval of the local medical society, and have the support of the county freeholders, boards of directors of Bergen Pines and the tuberculosis association, and health departments.

**Case-Finding Program**

Two years ago the association bought a chest X-ray bus with Christmas Seal funds. High school students, school personnel, industrial workers, and residents of communities are X-rayed.

The division of responsibility between the hospital and the association is clear cut.

The association plans schedules, conducts educational programs, has a receptionist on the bus, reports negative findings, is responsible for supplies and upkeep of the bus and for all follow-up.

The hospital supplies a driver and an X-ray technician, is responsible for taking and processing all X-rays, including retakes, and for reporting positive findings to family physicians. All X-rays are interpreted by Dr. Rufus R. Little, superintendent of Bergen Pines Hospital.

During the past year, 52,419 X-rays were taken on the bus—26,416 high school students and school personnel, 11,676 workers in small industries, and 14,327 residents in small communities. The total abnormal findings were 1,249, of which 403 were tuberculous and 846 non-tuberculous.

The bus operated 150 days, with an average of 349 X-rays per day. Patients, diagnosed through X-ray as having cardiac disorders, were referred to the association's cardiac service for follow-up.

**Follow-up Tuberculosis Nursing**

The association employs public health nurses to serve in about three-quarters of the county; the remaining area is covered by board of health nurses.

The nurses assume responsibility for follow-up of patients found in the surveys to require re-X-ray on a diagnostic film. Individuals who fail to respond to appointments for recheck are visited by the nurses. Of the 1,249 retakes requested in last year's surveys 82 percent was completed. In instances where patients did not report for re-X-ray (18 percent), the hospital superintendent made an interpretation of the 70-mm survey films and, in instances where a serious abnormality was suspected, notified the family physician. Further effort was made by the nurses to have these reluctant individuals report for recheck or see their physicians.

The association's nursing service is responsible for the routine tuberculosis follow-up. The service receives reports of all X-rays made in clinics in the area covered, together with recommendations from Bergen Pines.

The rehabilitation program was set up in 1940 with the aid of the National Tuberculosis Association's field staff. It began as a service for the tuberculous, but now includes patients with polio, cardiac disease, and cerebral palsy. Its services include a psychological and aptitude testing clinic, sponsored in part by Rotary Clubs; vocational and educational counseling and placement in cooperation with the State Rehabilitation and Employment Services.

The association employs two rehabilitation counselors, one stationed at Bergen Pines. In initiating the service at the hospital, the association employed an occupational therapist and established a library, both of which are now hospital responsibilities.

The counselor coordinates the school programs for patients of all ages, arranges for psychological and aptitude tests, aids in plans for study, training and employment in consultation with the hospital superintendent.

The association's rehabilitation director, who supervises the hospital program, continues the rehabilitation service recommended by the superintendent as the patients are released from the hospital.

Since polio patients are also treated at the hospital, they are included in the rehabilitation program while under treatment and after discharge.

Our constituents have some difficulty in knowing which worker is in the employ of the association, and which calls the hospital headquarters. The so-called "confusion" is considered a compliment, for it indicates that the hospital and the association are working cooperatively to bring about the best possible program of tuberculosis control for the residents of Bergen County.

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## X-RAY CITY EMPLOYEES

Arrangements are being made routinely to chest X-ray 3,000 city employees of Franklin County, Ohio. According to the Ohio Tuberculosis and Health Association, the cooperative project will be conducted by the Columbus Tuberculosis Society, Benjamin Franklin Hospital, and the Columbus Department of Health. The group to be X-rayed includes policemen, firemen, city hall workers, and employees of the health department.

# Expansion Into Other Respiratory Diseases To Be Explored by NTA

IN a statement of policy on expansion into health fields in addition to tuberculosis, the Board of Directors of the National Tuberculosis Association at its February meeting in Chicago recommended that infectious diseases of the respiratory system be included within the scope of activities of the NTA and its affiliates on "an exploratory and temporary basis" while the entire subject of expansion is further studied.

**Six-Month Study**

The action of the Board followed the report of the Committee on Program Development which, under the chairmanship of Dr. David T. Smith, has been studying the subject for the past six months. The action was based on recognition that in some areas the control of tuberculosis has progressed to the point where expansion into other health fields is justified and that, if such expansion is undertaken, uniformity of effort on the part of the affiliates and the National is advantageous.

In recommending infectious diseases of the respiratory system for first consideration as a possible field of broadened effort, the Program Development Committee pointed out that: (1) these diseases are closely related to tuberculosis, in that pulmonary tuberculosis itself is an infectious disease of the respiratory system; (2) they include a number of diseases of great economic and public health importance against which much less progress has been made than against communicable diseases spread through milk, water, and insects and, (3) they comprise a field of endeavor in which no voluntary national health organization is presently engaged.

Among the diseases in the group are the common cold, the influenzas, the pneumonias, such fungus diseases of the lung as histoplasmosis, actinomycosis, and coccidioidomycosis, and even certain childhood communicable diseases such as whooping cough, diphtheria, and the streptococcal throat infections.

**TB Main Task**

While authorizing exploration of other fields of activity, the Board reemphasized that efforts to control tuberculosis must be continued "undiminished" and restated its belief that the development of adequate official public health departments and official school health programs are an integral part of any program of tuberculosis control. At the same time, the Board pointed out that an affiliated association which wishes to branch out into this new health field must, as in the past, demonstrate to the satisfaction of the NTA Board that an adequate tuberculosis control program is being maintained and that the association is in a position to carry on other activities.

Whether or not expansion into some other health field will be undertaken on a long-range basis will be determined at a future date and will depend upon the outcome of a study of the whole subject which the Program Development Committee and the managing director were directed to make.

The complete resolution adopted by the Board follows:

*Whereas,* it appears to the Board of Directors of the National Tuberculosis Association that it is necessary at this time to adopt a statement of policy for the guidance and direction of its affiliates, its own committees, its managing director and staff on the subject of the expansion of its field of activity

*Now, Therefore, Be It Resolved* by its Board of Directors that the National Tuberculosis Association does hereby reaffirm its intention to continue its undiminished efforts in the field of tuberculosis control, and as an aid thereto to promote the development of official health units and official school health programs

*That,* inasmuch as there now exists a need in some areas and on the part of some of our affiliates for an expansion of program which has been brought about by advances made in the control of tuberculosis, and since, as these advances increase, the need for expansion of program will likewise increase, the new fields of activity must be common to both this association and all of its affiliates

*That,* on an exploratory and temporary basis this association will henceforth include within the scope of its activities the general subject of infectious diseases of the respiratory system and will authorize such of its affiliates as can demonstrate the need for expansion to do likewise, through the usual procedures for granting permission to engage in other activities

*That,* the Program Development Committee and the managing director are hereby authorized and directed to continue to study the subject of expansion by this association for the purpose of assisting the Board of Directors to determine the field of health activity which this association and its affiliates should include in their programs on a long-range basis.

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## NEGRO HEALTH WEEK

National Negro Health Week will be observed April 2-9, the Public Health Service has announced. The special objective of the program this year is an evaluation of the health gains made in the 36 years since the week was first observed and the planning of future activities to attain greater benefits.

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The Middlesex (Mass.) Health Association has voted to employ a part-time teacher for the Middlesex Sanatorium, according to the Massachusetts Tuberculosis and Health League.

## Health Education

### Nine fellowships for graduate study awarded by NTA and affiliates to health workers

Nine one-year fellowships in health education have been awarded by the National Tuberculosis Association and state and local affiliates to health workers from seven states and Puerto Rico under a program sponsored by the Association's Health Education and Personnel and Training Services.

Recipients of jointly-financed fellowships, their sponsors, and the schools where they are studying are:

Miss Alice I. Porter, Oklahoma Tuberculosis Association, University of Michigan School of Public Health; Walter Wenkert, New Haven (Conn.) Tuberculosis and Health Association, Yale University School of Medicine, Department of Public Health; Miss Wyntha Tompkins, Massachusetts Tuberculosis League, Yale University School of Medicine, Department of Public Health; Miss Elphy Puiles, Puerto Rico Tuberculosis Association, School of Tropical Medicine; William A. Parker, Virginia Tuberculosis Association and the Arlington County (Va.) Tuberculosis Association, School of Public Health, University of California; Miss Charlotte B. Mugnier, Tuberculosis Association of New Orleans (La.), School of Public Health, Columbia University.

#### NTA Awards

In addition, the NTA awarded a full fellowship to Miss Henrietta Strauss, New York, N.Y., who is studying at the Yale University School of Medicine, Department of Public Health, and partial fellowships to Joseph Murphy, Brooklyn, N.Y., and Miss Janet C. Allen, Dayton, Ohio. Mr. Murphy is at the School of Public Health, Columbia University, and Miss Allen is at the School of Public Health, University of California.

## NATIONWIDE TB CONTROL CONTEST

**The United States Junior Chamber of Commerce has announced a nationwide contest open to all local Jay Cee organizations based on the most "outstanding contribution to TB control." Pictured above (left) is Edward J. Walton, assistant managing director of the Brooklyn (N.Y.) Tuberculosis and Health Association and vice president and chairman of the New York State Junior Chamber of Commerce, receiving the trophy in the name of the national organization from the donor, Francis Powers, president of Powers X-Ray Service. The contest covers the period June, 1949 - May, 1950. The trophy will be awarded at the annual convention of the Jay Cees in Chicago in June.**

## SARANAC LAKE PATIENTS IN MASS REHAB STUDY

A large-scale study of the influence of personal, social, and emotional factors on the rehabilitation of tuberculosis patients will be conducted during the next 18 months among a group of several hundred patients now under treatment in and around Saranac Lake, N.Y.

The study will be carried out by the Saranac Study and Craft Guild in cooperation with the area's tuberculosis specialists and major sanatoriums. It will be financially supported by the Office of Naval Research under Contract NR onr-93400 and directed by Dr. Daniel H. Harris, clinical and research psychologist. Dr. Harris was formerly associated with the Central Office of the Veterans Administration as a rehabilitation specialist.

An attempt will be made to determine just which personal, emotional, and social factors, or what combinations of them are most important in aiding or blocking permanent recovery, either in general or in any given case.

Conclusions of the study will be used to lay the foundation for comprehensive programs of individual counseling and adequate action by community agencies to cut down relapses and step up the ratio of successful rehabilitation among future patients.

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## PROGRAM DEVELOPMENT SEMINAR HELD BY NTA

A seminar on program development was held by the National Tuberculosis Association at Carmel, Calif., Feb. 19-24. Approximately 35 state field workers and local secretaries from Arizona, California, Colorado, Nevada, New Mexico, and Oregon attended.

The seminar was the fourth of its kind to be held by the NTA during the past two years.

# Place of Drugs in TB Therapy Evaluated by Committee of ATS

IN a recent evaluation of drug therapy in tuberculosis, the Clinical Subcommittee of the Committee on Medical Research and Therapy, American Trudeau Society, points out that streptomycin is still the most effective anti-tuberculosis drug, but re-emphasizes that no drug is a substitute for bed rest and other established forms of treatment.

The complete report of the subcommittee is published in the March issue of the *American Review of Tuberculosis*, organ of the medical section of the National Tuberculosis Association. Dr. William B. Tucker of Minneapolis is chairman of the subcommittee.

"In many tuberculous conditions," the report states, "there is as yet no evidence that various drugs with anti-tuberculous properties lead to late results superior to those of such established forms of therapy as bed rest and collapse therapy, although the use of these drugs appears to be associated with perhaps temporary favorable changes more promptly and more uniformly."

**Several Unknown Factors**

The report points out that there are several unknown factors about drug therapy and cites two known handicaps to the use of any anti-tuberculosis drug—toxicity and the emergence of drug-resistant strains of tubercle bacilli.

"For these reasons," the report continues, "the committee believes that in general it is desirable to withhold drug therapy if other satisfactory therapy of a tuberculous condition is available, and looks with disfavor on the practice of utilizing drug therapy prior to institutional care or as an alternative to adequate bed rest, collapse therapy or other surgical treatment, in the hope that such procedures may be avoided."

While streptomycin "remains the drug of first choice in the treatment of various forms of tuberculosis," the committee suggests that the rate of emergence of streptomycin-resistant germs may be delayed with the use of para-aminosalicylic acid (PAS) in combination with streptomycin.

**Delaying Action**

"By reducing the incidence, or delaying the emergence, of streptomycin resistance," states the report, "combined therapy with streptomycin and PAS shows promise of decreasing to a significant degree the sharp therapeutic limitations which exist when streptomycin alone is employed. It should be emphasized, however, that the problem of streptomycin resistance has by no means been eliminated. Hence, careful integration of streptomycin with other forms of therapy and careful planning of the overall therapeutic attack continue to be matters of great importance if optimum results are to be achieved."

Regarding the thiosemicarbazone compound known as TB-1, which has been widely used in Germany in treating the tuberculous, the report emphasizes that extensive research on the drug is necessary before it can be evaluated. The committee suggests that the research be directed at the bacteriological, pharmacological, physiological, chemical, toxicological, and clinical aspects of the uses of the compound. Such research, the report states, will indicate whether the thiosemicarbazones should be used as primary drugs or as adjuncts to other drugs in tuberculosis.

The report points out that aureomycin has been found to be "entirely ineffective" in the treatment of tuberculosis, that sufficient information is not available as to the effect of chloramphenicol (chloromycetin) to permit a statement at present, and that neomycin, while active against the tubercle bacillus in the test tube and in animals, "is as yet too toxic to be of value in the treatment of human tuberculosis."

"Unless toxicity can be reduced by further purification or by chemical alteration in the structure of the drug," the report concludes, "use of neomycin for the treatment of patients cannot be recommended at present, even on an experimental basis."

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## NTA CORPORATION TO MEET IN APRIL

In compliance with its charter and by-laws, the National Tuberculosis Association will hold the annual meeting of the corporation at 120 Exchange Street, Portland, Maine, on April 26 at 10:00 A.M., in the office of Wadleigh B. Drummond, clerk.

Among the items of business will be consideration and action on changes in the purposes of the organization contained in the Certificate of Organization of the Association so that said purposes shall be as follows:

(a) To disseminate knowledge concerning the causes, treatment, and prevention of tuberculosis and of related health problems;

(b) To study tuberculosis in all its forms, and other related diseases;

(c) To encourage the prevention and scientific treatment of tuberculosis;

(d) To stimulate, unify, and standardize the work of the various tuberculosis associations throughout the country;

(e) To cooperate with medical societies and with other non-official and official organizations interested in tuberculosis and related health problems;

(f) To promote international relations in connection with the study and control of tuberculosis and related diseases.

## Health in Colleges

### Growth in tuberculosis control programs noted in report of College Health Assn.

More American colleges now have tuberculosis control programs in effect than ever before, according to the 18th annual report of the Committee on Tuberculosis, American College Health Association.

During the year 1947-1948, tuberculosis control programs were reported by 374 colleges as against six colleges in 1932. In the intervening years, the increase in such programs has been steady, the committee reports.

**Less Than Fifty Per Cent**

The committee states, however, that the 374 colleges reporting programs amount to less than half of the 889 queried. Replies were received from 438 colleges, 85 per cent of which reported some form of tuberculosis control program. It is assumed that the majority of colleges which failed to reply to the inquiry have no tuberculosis control programs.

The 374 colleges having programs reported a total of 968 cases of tuberculosis found in an enrollment of 979,595—an average af about 99 cases per 100,000, or a lower average than that found in adult groups which is usually 300 to 500 cases per 100,000.

The colleges with no case-finding programs reported only about 1.6 cases per 100,000 enrollment.

Twenty-four cases of tuberculosis were found among faculty and administrative staffs in colleges having case-finding programs but no such cases were reported by colleges without such programs. Among food handlers and other employees, colleges with programs found 71 cases; colleges without programs, only 1 case.

On the credit side of the ledger, the report indicates that a total of 960 students, their tuberculosis arrested, have returned to college.

Conclusions reported in the committee's findings include:

The New England and the East North Central regions show the largest percentages of colleges with tuberculosis control programs. The North West Central region leads in combined programs of tuberculin testing and chest X-ray.

The percentage of reactors to tuberculin tests among college students fell from 18.6 per cent in 1947 to 15.8 per cent in 1948.

In general, colleges with larger enrollments have better facilities for tuberculosis control. There is a need for stimulation of control programs among the smaller schools.

The committee reiterated its recommendation for increased tuberculosis control in colleges. It emphasized preference for combined tuberculin testing and chest X-ray, urged that the college tuberculosis control program be integrated with the total college health program, and urged the careful consideration of guidance, recreation, nutrition, sanitation, and housing in plans for healthful college living.

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## Postgraduate Courses

### Sessions on pulmonary diseases set for Memphis and Pittsburgh in March and May

The American Trudeau Society, medical section of the National Tuberculosis Association, will sponsor postgraduate courses in pulmonary diseases at Memphis, Tenn., and at Pittsburgh, Pa., in March and May, respectively.

The first session, for Region III, will be held March 20-25 in cooperation with the University of Tennessee Medical School. It is intended primarily for physicians from Florida, District of Columbia, Georgia, Kentucky, Maryland, North Carolina, South Carolina, Tennessee, and West Virginia.

Dr. Duane Carr of Memphis is chairman of the Regional Planning Committee and Bryan Wilson, executive director of the Shelby County (Tenn.) Tuberculosis Society, is in charge of local arrangements.

The second session, for Region II, will be on the relation of pulmonary diseases to employment. It will be held May 15-20 in cooperation with the University of Pittsburgh School of Medicine and Graduate School of Public Health and the Industrial Hygiene Foundation of America, Inc.

Intended primarily for physicians from Delaware, New Jersey, New York, and Pennsylvania, the course is under the direction of Dr. C. Howard Marcy of Pittsburgh. Andrew W. Kovacs, Tuberculosis League of Pittsburgh, is in charge of local arrangements.

Applications for both courses may be obtained from the American Trudeau Society, 1790 Broadway, New York 19, N.Y.

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## "HEALTH" IS ADDED TO SOCIETY'S NAME

A change in name from the Pennsylvania Tuberculosis Society to the Pennsylvania Tuberculosis and Health Society was recently announced by Arthur M. Dewees, executive secretary.

The new name is in line with the society's policy of participation in a broader field of public health service while continuing as its major task the prevention and control of tuberculosis in the state.

This is the second change in name since the organization's founding in 1892 by Dr. Lawrence F. Flick as the Pennsylvania Society for the Prevention of Tuberculosis.

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## CITY X-RAY UNIT

The Bureau of Tuberculosis, New York City Department of Health, recently placed its first mobile X-ray unit in operation, according to the *New York State Journal of Medicine*. The $25,000 unit will be used in bringing chest X-ray services to residents of the city's five boroughs.

# THE PRESIDENTS' COLUMN

By EMMELINE J. RENIS, President, NCTS

TIMELY and challenging is the report of the American Trudeau Society's Joint Committee on Medical Education, based on its October, 1949, meeting in Chicago. Setting a chart for more emphasis on pulmonary diseases in the medical colleges and for further realistic action to make the general practitioner TB-minded and TB-informed, it is a milestone report that deserves wide consideration.

Unlike many a good report that is buried in files, it may be predicted that this report will become a little testament for future action. It enunciates a carefully-reasoned approach that holds interest for all of us. It reminds us of another important subject—nursing education, with which the National Tuberculosis Association and the National Conference of Tuberculosis Secretaries, particularly the Advisory Committee on Health Education, are profoundly concerned.

**Allied Effort Needed**

It is heartening to note that vigorous action is being taken within the medical fraternity to further TB-awareness. We believe that the program which the ATS committee recommends can best prosper with the cooperation of both the medical and non-medical wings of our movement. We who distribute the monthly *Tuberculosis Abstracts* to the general practitioners will be on the lookout for other literature that the committee recommends. We should drum away, too, on public health aspects of TB in bulletins, institutes and talks serving the medical group locally.

For example, we need to report clearly to our doctors on our work and plans. We need to emphasize that no statistics can be better than the willingness of the doctors to report cases of tuberculosis which they find in their day-to-day practice. Working through its medical spokesmen, the local association can stress the importance of the X-ray to supplement the stethoscope in chest examinations, the importance of consultation on questionable X-ray films, understanding of medical-social service, rehabilitation, and such other vital aids that the doctor can array in his task of optimum restoration of the patient.

**Have We Done Our Best?**

We may ask ourselves whether we have done our best in keeping the medical fraternity familiarized with our association's program. The typical doctor is an acknowledged community leader. His intimate consultation with the patient puts him in strategic position to sell the association's work. We need to count on the doctor as a good teacher, well able to help inform the community on the part each citizen must play. We want our family doctor to be not only alert to look for TB, but aware of the assistance available to him through various agencies.

The association with a medical school in its territory should link itself in cordial relationship with the school so that the best may be accomplished in implanting both medical and public health aspects of TB. Whether or not an association has a medical school at hand, it still needs to explore the good work that it can do to channel information and maintain teamwork with the general practitioners. It needs to be alert to support such approved legislative measures as will further sound and practical medical education aims. Whether or not we have a medical school in our community, we do have the representative output of our medical schools, and we must be properly concerned that these young doctors have TB-awareness.

We believe that the prevailing attitude in the medical fraternity toward all this is good. Locally, to cite a close-at-hand case, our association for several years has conducted training for medical and nursing students in TB control. In cooperation with hospital authorities, a progressive program goes forward for nursing students and a gratifying program is being conducted for Baylor Medical College students. Asked whether they wanted *Tuberculosis Abstracts* continued, five out of seven doctors promptly expressed appreciation for the *Abstracts* and asked to be kept on the mailing list.

**Liaison Committee**

It would seem fundamental for the local association to have in its program a medical committee as liaison between the association and the medical fraternity at large.

Much could be said about need for greater action to secure well-rounded TB control training in nursing curricula. Tuberculosis should be a basic subject in all schools of nursing, not only in lecture form but with opportunity for actual bedside care of patients and with opportunity for some TB diagnostic clinic experience, followed by visits into the homes of patients. Cooperation between various institutions concerned can make this possible. The local association can point the way.

## Mass Surveys

### Millions X-rayed during past year in rapid screening of large city populations

Rapid tempo mass chest surveys, conducted during the past year in six large American cities, have piled up an impressive number of X-rays taken. Similar surveys now in progress and others in prospect promise like results.

All the surveys have been carried out through the cooperative efforts of the Public Health Service, state and local health departments, and tuberculosis associations.

Fifteen to 24 small-film X-ray units are being provided by the PHS, as well as technicians and other personnel for the actual conduct of the surveys.

**Cleveland Leads**

According to figures received by the National Tuberculosis Association, the survey conducted in Cleveland, Ohio, between March 5 and Aug. 2, 1949, tops the list with a total of 688,204 films taken.

Boston, Mass., is in second place with a total of 531,000 X-rays taken during the period, Sept. 21, 1949-Jan. 14, 1950.

Denver, Colo., completed a two-month survey on Aug. 31, with a total of 326,326 films, and Spokane, Wash., took a total of 107,793 X-rays in a month-long survey last April.

Tacoma, Wash., where 73,736 persons were X-rayed between Feb. 1 and March 3, was the first large city to conduct a survey in 1949.

Salt Lake City, Utah, chalked up a total of 162,854 films during the period Oct. 5-Nov. 5.

**Los Angeles Scheduled**

A survey conducted in San Diego, Calif., between Dec. 6, 1949, and Jan. 31, 1950, had as its goal a total of 300,000 X-rays. At the present time, no figures are as yet available.

A goal of two and a half million X-ray films has been set for a survey scheduled to begin this month in Los Angeles.

## KANSAS UNDERTAKES STATE-WIDE SURVEY

A state-wide X-ray survey is under way in Kansas under the sponsorship of the Division of Tuberculosis Control, Kansas State Board of Health. The Kansas Tuberculosis Association and local medical societies are cooperating in the project.

The survey, which is expected to take approximately three years to complete, will cover every county in the state. All residents over 16 years of age will be examined.

Using two mobile units, the survey teams will move from county to county. A third unit will be used to cover all state, public, and private institutions of higher learning.

Surveys will be made only at the invitation and approval of the local medical society or, where none exists, by the local health officer. Assistance in making arrangements for the surveys will be given communities by health educators from the state tuberculosis association.

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## TEACHERS STUDY ROLE IN HEALTH OF PUPILS

The teacher's role in the health of the school child was studied by a group of 41 New York City teachers in a four-month credit course under the auspices of the Central Harlem Health Center of the New York City Department of Health and the Harlem Tuberculosis and Health Committee of the New York Tuberculosis and Health Association.

Sponsored by Assistant Superintendents Dr. Clare C. Baldwin and R. George Zuckerman of the New York City Board of Education, the course was held Sept. 28, 1949—Jan. 25, 1950, at the Harlem Health Center.

Topics under discussion included modern school health services; community health problems; growth and development of the school child to and during adolescence; school health program procedures; the importance of teacher observation and the proper use of the health record card; nutrition; newer knowledge in dental caries control; emotional behavior of school children; the role of the teacher in the tuberculosis control program; common contagious diseases; the handicapped child; environmental sanitation; school and home safety, and community resources, medical, health education, and recreation.

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## NEW RADIOLOGY UNIT IS ANNOUNCED BY PHS

Formation of a new unit under the Public Health Service to develop a radiologic health program to meet potential health hazards created by increased use of radioactive materials and radiation-producing machinery has been announced by the PHS.

The Radiological Health Branch will correlate radiologic health activities in the PHS, develop a training program in radiologic health for service officers and other public health workers and act as a source of information for other units of the service, other federal agencies, and state and local health agencies.

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## WHO SPECIALISTS SURVEY ITALY'S HEALTH SERVICES

A survey of Italy's public health services was made last summer by specialists from the World Health Organization and the Rockefeller Foundation to help the Italian government reorganize its public health services so as to take advantage of modern scientific methods in the prevention of disease and the maintenance of health.

According to *Science*, publication of the American Association for the Advancement of Science, the survey covered such fields as tuberculosis, malaria, venereal diseases, maternal and child health, industrial hygiene, and public health statistics. It was made under the auspices of the Italian High Commissariat, assisted by the WHO and the Rockefeller Foundation.

# Local Health Units

## Countrywide Need for Minimum Basic Local Health Services Demands Creation of Many More Adequately-Staffed, Full-time, Local Health Departments

By HAVEN EMERSON, M.D.*

WHAT are health units? Why are they needed? What will they bring to people's health and happiness? What will they cost? Can we do without them? Is this just a bright idea of a few public health fanatics or a basic principle of democracy? Has the idea grown naturally or did it die aborning? What is the national picture?

A health unit is a population group of 50,000 or more served by a single full-time medical health officer and associated staff appointed by local government, and largely paid for out of local tax funds, performing at least six basic public health functions. This population unit within a single local health jurisdiction may be a part or all of one county, or two or more counties or parts of counties.

**Needed Countrywide**

Full-time adequately staffed local health departments are needed for every person and every area of the United States, because without this structure of civil government service the sciences of preventive medicine can not be applied through authority and education for social ends in the most effective and economical manner.

We cannot do without the organization, personnel, and maintenance of such a local health service because effective official and voluntary health promotion of a community depends on the leadership and retail delivery of public health of such an agency of civil government.

The idea of local health units, far from being the fancy thought of a few, is more widely endorsed by every variety of professions, civic, official, and volunteer medical, nursing, and teacher groups than in the case of any public health proposal of the past half century.

Since 1942, when the proposal of health units for the nation was first advised and studied, the percentage of population of the United States covered has increased from about 62 to about 70.

**1,490 Counties Covered**

There are now 1,212 such units covering 1,490 counties; approximately 102,000,000 of our people live in such units and more than 40,000,000 live in communities lacking this essential of a self-determining, democratic form of local government.

The idea took form under the pressure of active war. We were and we remain unprepared for the emergencies and routine services of peace as for the catastrophes and urgent demands of war, as long as there is any community of people not within the jurisdiction of a full-time health department.

Action was postponed by the pressure of war. Personnel shortages have persisted. Recruitment and training await convinced public demand and support.

Local public health administration for at least 40,000,000 fellow Americans remains in the horse and buggy stage while preventable disease of body and mind travels by '50 model automobile and airplane.

There are six basic functions of a local health service, without which public health is little more than lip service and gesture. They are:

Public health statistics, communicable disease control, environmental sanitation, public health laboratory service, maternal and child hygiene, and public health education.

The 16 persons indispensable for the minimum basic local health services of a population group of 50,000 are:

One medical officer of health, one sanitary or public health engineer, one assistant sanitarian, ten public health nurses, one a supervisor, and three office staff, the numbers to be increased according to recognized professional requirements in proportion to population.

To maintain local autonomy, self-respect, and sense of responsibility, not less than half the cost should be borne by the tax levy of the local jurisdictions included in the unit, the rest to be obtained, if necessary, from state and federal grants.

**Pressure Needed**

In 1934, Dr. Thomas Parran, later Surgeon General of the Public Health Service, said that at the then rate of progress towards total coverage, it would take 100 years to complete local health administration for the United States. We are concerned with nudging progress to make it step more briskly.

Only one pressure can be trusted to do the job, namely the convictions and decisive actions of the members of every community, that they will have only the best in public health and that they want this provided by their local governments, and, if necessary, made compulsory by act of legislature.

One way of making the weight of informed opinion effective is to provide under present permissive legislation for referendum vote of the populations concerned.

The people must be made aware of their present disabilities and encouraged to take the matter into their own hands. Opinion and action must be organized, interest must be maintained until no one in the country lacks at least the minimum basic local health services provided by their own full-time health officer and qualified assistants.

*Chairman, Subcommittee on Local Health Units, American Public Health Association. Dr. Emerson's article is an abstract, brought up to date, of "Full-Time Health Units at This Mid-Century," which he presented at the 1949 meeting of the New York State Committee on Tuberculosis and Public Health of the State Charities Aid Association.

## AGENCIES ASK X-RAY FOR FOSTER FAMILIES

A plan to periodically X-ray all adult members of foster families as a protective measure for the children under their care is being worked out in Hennepin County, Minn., by a joint committee representing child placement and health and welfare agencies.

At the present time, physical examinations are required of foster families at the time of licensing but no further examination is required. The committee feels that while annual physical examinations as a requirement for re-licensing is not practicable at this time, the compromise goal of yearly chest X-rays is feasible.

An invitation to participate in the plan is being extended to all agencies in Hennepin County and the committee anticipates that agencies in neighboring Ramsey County will adopt a similar program.

Agencies represented on the committee include the Hennepin County Community Chest and Council, Hennepin County Welfare Board, Children's Home Society, Family and Children's Service, Children's Friend Society, Lutheran Welfare Society, Lutheran Children's Friend Society, Jewish Family and Children's Service, Catholic Welfare Association, Hennepin County Tuberculosis Association, and the Minneapolis Public Health Center.

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## ROUTINE X-RAY PROGRAMS

The W. B. Plunkett Memorial Hospital in Adams, Mass., has begun its third year of routine X-raying of all adult hospital admissions, according to the Massachusetts Tuberculosis and Health League. Also, according to the League, the Fairview Hospital in Great Barrington will begin immediately a similar program. The Berkshire County Tuberculosis Association will give financial support to both projects.

## FOUR-COUNTY PROJECT SET BY ILLINOIS ASSN.

Four Illinois county tuberculosis associations—Hardin, Johnson, Pope, and Massac—have joined forces with the state association in a project aimed at coordinating their efforts in order to more effectively combat the high incidence of tuberculosis in the area.

The Illinois Tuberculosis Association is helping finance the project and has named Robert J. Utzinger, a former ITA junior staff member, as area secretary. He will be attached to the ITA staff but will supervise program planning, health education, rehabilitation, case finding, and Christmas Seal Sale activities in the four counties.

### Integrating TB Services

. . . *Continued from page* 36

6. Is the man on the street aware of the cost of this disease to him as a taxpayer?

7. How many residents know what causes tuberculosis, how it can be prevented and what are the advantages of public tuberculosis hospitals?

8. Are facilities for early diagnosis available without cost to the individual?

9. Are there adequate diagnostic and follow-up clinics which are easily available to all sections of the area?

10. Is there an adequate number of beds available for the treatment of patients?

11. What is the quality of medical care in any given community?

12. Are the clinical facilities now available in the hospital brought to all the people and what are the opportunities for free consultation with physicians?

13. Are all physicians aware of the fact that the presence of tuberculosis is a symptom of some social and public health problem in the community?

14. Are welfare departments aware of the need for adequate family assistance as a community investment to prevent disease rather than as a mere expenditure of public funds?

Only if the significance of these questions is fully appreciated and only if all related agencies attack the problem on a solid community front can the optimum of possible benefits be realized.

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## VIRGINIA CITY BEGINS MULTIPHASIC TESTING

A mass testing program for seven chronic diseases was begun on Jan. 1 by the Richmond (Va.) City Health Department, the U.S. Public Health Service, and local agencies. Residents will be tested free for pulmonary tuberculosis, heart disease, diabetes, high blood pressure, anemia, obesity, and syphilis.

The program is financed by a grant of $40,000 from the USPHS, to be matched in services and equipment from the city health department.

### Patient Morale

. . . *Continued from page* 34

long illness, recreation—upon which most of us depend far more than we realize—becomes necessary mental hygiene. Provision for recreation is too often left out of tuberculosis hospital planning and hospital budgets. Internists may know its importance, but appropriating officers have to be shown what it has to do with disease control. Thus, in planning first things first, last things are sometimes wholly forgotten. The adequacy of last things may affect the success of first things.

In the long run, more public hospitals must relinquish the poor-farm traditions which hamper their effectiveness. The process of modernization includes humanization and both contribute to effective therapy.—*Holland Hudson, Director, Rehabilitation Service, NTA.*

## TB CENTER IS SET UP IN OHIO PRISON SYSTEM

A new tuberculosis control unit, which eventually will care for all male adult prisoners with tuberculosis in Ohio's prison system, has been established at the London Prison Farm in Madison County.

The 100-bed unit is composed of separate wards for active and convalescent cases, has complete X-ray and treatment rooms, and will be supervised by Dr. Damon E. Wetterauer, tuberculosis specialist and consultant to the Division of Corrections.

In order to detect tuberculosis and eventually provide for systematic segregation of diseased inmates, mass chest X-ray surveys have been conducted in the various prisons and mental institutions in cooperation with the Ohio Department of Health. In recent months, surveys have been conducted at Mansfield Reformatory, London Prison Farm, and the Women's Reformatory at Marysville. The Ohio Penitentiary population is in the process of being X-rayed.

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## X-RAY NAVY EMPLOYEES

A total of 262,341 Navy civilian employees were X-rayed between March, 1948 and June, 1949, according to the Public Health Service Tuberculosis Control Division's *Newsletter*. The group included workers employed both in the continental United States and overseas. Five out of every 1,000 examined were found to have evidence of tuberculosis requiring immediate attention, and three out of every 1,000 were found to have evidence of other chest conditions, such as lung tumors and heart disease.

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More than 50,000 persons received chest X-rays from the Brooklyn (N.Y.) Tuberculosis and Health Association during the calendar year, 1949.

# PEOPLE

*Arizona*—Mrs. Frances L. Woodward recently joined the staff of the Arizona Tuberculosis and Health Association as an area secretary for the northwestern part of the state. Mrs. Woodward was at one time health educator for the Davidson County (Tenn.) Tuberculosis Association.

*California*—Laurence R. Kirk has been named executive secretary of the California Tuberculosis and Health Association, succeeding Dr. Chesley Bush who has served as acting director since the death of Ford Higby in June, 1949. Mr. Kirk has been with the association as assistant executive secretary since 1948 and prior to that was executive secretary of the Sacramento association for five years.

Mrs. Dalrie Lichtenstiger has been appointed executive secretary of the Los Angeles County Tuberculosis and Health Association.

*Florida*—Mrs. Jean Valdespino has joined the staff of the Florida Tuberculosis and Health Association as its first junior staff member.

*Georgia*—Carl Fox, director of health education for the Illinois Tuberculosis Association, is the new executive secretary of the Georgia Tuberculosis Association. Mr. Fox succeeded L. L. Young who resigned last year. Miss Agnes Gerding of the National Tuberculosis Association's Program Development staff has been serving as acting executive secretary.

*Indiana*—Thomas F. Jordon has succeeded Stewart C. Bailey as health information secretary for the Marion County Tuberculosis Association. As part of his work, Mr. Jordon will initiate a year-round voluntary speakers' bureau. Mr. Bailey will continue with public relations work in Albuquerque, N. M., and plans to attend the graduate school of the University of New Mexico.

Dr. Helen Taylor Miller, statistical analyst, has joined the staff of the Marion County Tuberculosis Association. She will assist in the self-evaluation project now under way.

*Illinois*—Miss Maryhelen Vannier, former director of the Department of Health and Physical Education at Drake University in Des Moines, Iowa, and St. Lawrence University, Canton, N.Y., has joined the health education staff of the Tuberculosis Institute of Chicago and Cook County.

Edward F. Bamford, a former teacher of sociology at Baylor University, Pennsylvania State College, and the University of Illinois, has joined the institute's rehabilitation staff. He will evaluate rehabilitation services available at the Municipal Tuberculosis Sanitarium and analyze problems faced by patients after leaving the hospital.

*Kansas*—W. W. Wilmore, associate executive secretary of the Kansas Tuberculosis Association for the past two years, became executive secretary of the association March 1. Mr. Wilmore succeeds Dr. Seth L. Cox who will retire May 31.

*Maryland*—Miss Mary Jean Reinhard has been appointed executive secretary of the Allegany County Tuberculosis Association.

*Massachusetts*—David A. Bowers, former rehabilitation field secretary of the Massachusetts Tuberculosis and Health League and recently re-

## PEOPLE

habilitation coordinator at Westfield State Sanatorium, has been named rehabilitation director for the league.

Miss Grace T. Fitzgerald has joined the staff of the Berkshire County Tuberculosis Association as rehabilitation consultant.

Mrs. William Sutton began her teaching duties at the Middlesex County Sanatorium in January. The position was created recently by the Middlesex Health Association.

Mrs. Vera Miller Epstein, R.N., has succeeded Miss Mary Fitzgerald as executive secretary of the Holyoke Tuberculosis Association. Miss Fitzgerald has accepted a position as health educator with the Massachusetts Division of the American Cancer Society.

*Minnesota*—Dr. Russell H. Frost, area tuberculosis chief for the Fort Snelling Area Medical Office, Veterans Administration, has been named to succeed Dr. Ernest S. Mariette as superintendent of Glen Lake Sanatorium. A graduate of the University of Minnesota School of Medicine, Dr. Frost served as senior resident physician at Glen Lake in 1928 and as superintendent and medical director of Buena Vista Sanatorium, Wabasha, Minn., and of the G. B. Cooley Sanatorium, Monroe, La.

*New York*—Dr. Donald B. Armstrong has been re-elected president of the New York Tuberculosis and Health Association. Elected to serve with Dr. Armstrong are Dr. Oswald R. Jones, first vice president; Dr. Grant Thorburn, second vice president; Myron I. Borg, Jr., secretary, and H. P. Davison, treasurer. Judge Hubert T. Delany of the Domestic Relations Court of the City of New York was elected to the association's board of directors. Reed B. Dawson, lawyer and legal counsel for the New York County Medical Society; Daniel C. McCarthy, publicity director, Socony Vacuum Oil Co., and A. Wells Peck, president, Peck and Peck, were elected to the association's executive committee.

Miss Louise Campbell, health education consultant National Tuberculosis Association, has been appointed executive secretary of the New York City Hospital Visiting Committee of the State Committee on Tuberculosis and Public Health, State Charities Aid Association.

George J. Nelbach, who served as executive secretary of the State Committee on Tuberculosis and Public Health, State Charities Aid Association, for 36 years before his retirement in 1947, has been awarded honorary life membership in the organization.

Miss Helen Mackenzie is the newly-appointed executive secretary of the Cattaraugus County Tuberculosis and Public Health Association.

Miss Marion V. Miller has joined the school health education staff of the Nassau County Tuberculosis and Public Health Association as health consultant.

*Nicaragua* — Dr. Camilo Vijil y Tardon of Managua has been named a member of the Expert Committee on Tuberculosis of the World Health Organization at Geneva. He will serve for two years as a medical officer in special training.

*Ohio*—Mrs. Virginia Benton has been named director of public relations for the Columbus Tuberculosis Society. A graduate of the University of Maine, Mrs. Benton has edited a weekly newspaper in Maine, authored a column in the Lynn (Mass.) *Daily Evening Item*, written continuity for radio stations in Massachusetts and Connecticut, directed publicity for Community Chest campaigns in Lynn, (Mass.) and was public relations director for the Lynn chapter of the American Red Cross in 1948.

*Pennsylvania*— Chalmers C. Stroup, Jr., field worker for the Pennsylvania Tuberculosis and Health Society, has been named health education secretary of the Lehigh County Tuberculosis and Health Society. Mr. Stroup succeeds Robert Mentzell who has resigned to take up other work.

*Rhode Island*—Dr. Ubaldo E. Zambarano, executive secretary and medical director of the Providence Tuberculosis League, is the newly-elected president of the Providence Medical Association. Dr. Zambarano served for two years as a member of the Board of Directors of the National Tuberculosis Association.

*Tennessee*—J. K. Davis has been named executive secretary of Negro programs for the Shelby County Tuberculosis Association. He succeeds Mrs. Montee Falls who resigned recently.

*Utah*—Joseph Carling is the new executive secretary of the Utah Tuberculosis Association, succeeding Miss Ada Taylor Graham who retired recently. A graduate of the Utah State Agricultural College, Mr. Carling has done graduate work at the University of Michigan and since 1942 has been associated with state and district health departments in Utah and Washington as a sanitarian, health educator, and health education consultant.

*Washington* — Mrs. Edythe Tucker, formerly health coordinator for the Bremerton public schools, has been appointed school health educator for the Anti-Tuberculosis League of King County.



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